U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 26 June 2007

In the Matter of:

D. F.,
Claimant,

CASE NO: 2006-BLA-5836

v.

SLAB FORK COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Derick W. Lefler, Esq.
For the Claimant

Christopher M. Hunter, Esq.
For the Employer

Before: LARRY W. PRICE
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This matter arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. 901 *et seq.* (Act), and applicable Federal Regulation, mainly 20 C.F.R. Parts 412, 718, and 725 (Regulations).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to coal workers' pneumoconiosis or to the survivors of persons whose death was caused by coal workers' pneumoconiosis. Coal workers' pneumoconiosis is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. 902(b).

On June 7, 2006, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Pipestem, West Virginia, on December 7, 2006. At the trial I admitted Director's exhibits[1] 1 through 32, to the extent that they comply with the evidentiary limitations at 20 C.F.R. § 725.414 (2004) and Employer's exhibits 1 through 6.[2] I excluded EX 7 through 9 because these exhibits were comprised of x-ray interpretations that were in excess of the limitations and Employer did not show good cause for admission of these exhibits. I identified the Claimant's evidence summary form as ALJ 1, and Employer's evidence summary form as ALJ 2.

ISSUES

The parties have stipulated to the following issues, and I therefore find the following facts:

- That Claimant was employed in the coal mining industry for 11 years, 2 months.
- That Claimant's wife is recognized as a dependant under the Act.

The following issues remain for resolution:

- Whether Claimant is a Miner under the Act.
- Whether Employer is the Responsible Operator.
- Whether Miner suffers from pneumoconiosis.
- Whether pneumoconiosis arose from coal mine employment.
- Whether Miner has a totally disabling pulmonary impairment.
- Whether the total disability is caused by the pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Miner filed the present claim for Black Lung benefits on May 12, 2005. (DX 2). The District Director initially concluded that Miner would receive benefits in the Schedule for the Submission of Additional Evidence. (DX 21). However, following the submission of additional evidence the District Director issued a Proposed Decision and Order denying benefits on February 22, 2006. (DX 24). The District Director found that Miner did have pneumoconiosis and that the disease was caused, at least in part, by coal mine work. However, the District Director concluded that the evidence did not show that the pneumoconiosis caused a breathing

[1] The following abbreviations have been used in this decision: DX – Director's Exhibit; EX – Employer's Exhibit; CX – Claimant's Exhibit; TR – Transcript of the December 7, 2006 hearing; BCR – Board certified radiologist; and B – B-Reader.

[2] Claimant objected to EX 3, arguing that the X-rays included in the exhibit were in excess of the regulations. I overruled Claimant's objection because the x-rays were taken for the purpose of treating Miner's medical condition and were therefore considered treatment records. The regulations do not place a limitation on treatment records.

impairment of sufficient degree to establish total disability within the meaning of the Act and the Regulations. Miner requested a hearing on March 7, 2006. (DX 27).

Miner and Post 1969 Employment

Miners who establish the applicable elements of entitlement may receive benefits under the Act. 30 U.S.C. § 901(a); 20 C.F.R. § 718.1(a) (2003). A "miner" is defined as "any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal...." 20 C.F.R. § 718.202(a) (2003). The regulations provide a rebuttable presumption that "any person working in or around a coal mine or coal preparation facility is a miner." Id. In this case, Claimant worked for a coal company as a foreman for 11 years. (Tr. at 13 - 14). The record contains no evidence to rebut the presumption that Claimant is a miner. The Social Security records show that Claimant had worked as a Miner after December 31, 1969. (DX 6). I find that Claimant is a miner under the Act and that he was employed in the mines after December 31, 1969. Claimant will hereby be referred to as "Miner."

Responsible Operator

In order to be deemed the responsible operator liable for the payment of benefits, an employer must have been the last employer in the coal mining industry for which the miner had his most recent period of coal mine employment of at least one year, including one day after December 31, 1969. 20 C.F.R. §§ 725.492(a), 493(a) (2004). The regulatory amendments at 20 C.F.R. §725.495(c)(2) (2001) require that the designated responsible operator establish "[t]hat it is not the potentially liable operator that most recently employed the miner." The Social Security records show that Miner's last full year of coal mine employment was in 1982 at Slab Rock Coal Company. (DX 6). Therefore, I find that Slab Rock Coal Company is properly named as the responsible operator in this claim.

Miner's Testimony

Miner was born September 11, 1941. At the time of the trial, he had been married for 42 years. He has been working in automobile sales since 1983. Prior to selling cars, he worked for Slab Fork Coal Company at the Alpoca mines. He started off "shoveling ribs" and worked his way up to foreman, which was his last job in the coal mines. (Tr. at 12). He was a working foreman; he "did all phases of duties from running the equipment to setting the water pumps, or whatever needed to be done. Handling rock dust, pulling cable…" (Tr at 13). He testified that his job wasn't any easier than the positions held by his co-workers. He lifted more than 50 pounds numerous times a day. He began working with Employer in 1971. He testified that they shut down in 1982, and he never returned to coal mine employment. (Tr. 13).

Miner stated that he had trouble with his breathing for over fifteen years. As a car salesman, he had to move from a big lot to a smaller lot due to his breathing difficulties. He testified that the last 6 – 7 years have been the worst and that he had been using oxygen for between one and two years. He reported that he kept a tank of oxygen in his car during work; on occasion he would have to use the oxygen for between 30 and 40 minutes on a given work day. He uses oxygen every night. (Tr. at 16 - 17). He also mentioned that he had trouble breathing

upon exertion, for example during strenuous walking, yard work or walking on an incline. He testified that extreme temperatures also brought about breathing difficulties. (Tr. at 18).

Smoking History

The record contains varied statements regarding the Miner's smoking history. Miner testified that he had been smoking approximately six cigarettes a day for the previous year. He started smoking in 1960. He had smoked an average of half a pack per day. He quit once for four years, and another time for six months. (Tr. 14 – 15). Miner therefore admits to a 20.55 pack year smoking history. [3] Dr. Mullins listed a smoking history of half a pack per day for 46 years. (DX 11). Dr. Castle reported a smoking history of roughly half a pack per day for 45 years. (EX 2). Dr. Hippensteel's report listed a smoking history of between one third and one half a pack of cigarettes for 10 years, however, after reviewing additional medical data, Dr. Hippensteel noted a smoking history of 46 years. (DX 13). The hospital records list a smoking history of between 1 and 2 packs a day for 50 years. (EX 3). Based upon all of these accounts, I do believe Miner smoked for a total of 46 years. The treatment records list a smoking history of 50 years at *1 – 2 packs per day,* which is more than double that listed anywhere else in the record. Treatment records may be more credible because information is typically given to the hospital for the sole purpose of receiving the best possible treatment. However, every other reference to Miner's smoking history lists the usage to be approximately half a pack per day. Therefore I find that Miner has a 23 pack year smoking history.

MEDICAL EVIDENCE

X-ray Reports

Exhibit	Doctor	Qualifications	Date of X-ray	Date of Reading	Film Quality	Interpretation
EX 2	Castle	B	3/7/06	3/17/06	2	Negative, co, ef
EX 3	Ahmed	B	2/14/06	2/14/06		"Minimal plate-like atelectasis behind the sternum in the lateral view, poor inspiratory effort showing prominent heart size to mild cardiomegaly. Right peripheral pleural thickening and blunting/scarring of costrophrenic angles. No significant new pneumonic infiltrates."
DX 13	Hippensteel	B	12/7/05	12/7/05	1	negative, cg, co, pi
EX 3	Ahmed	B[4]	9/27/05	2/27/05		Cardiomegaly, COPD, right peripheral pleural thickening and blunting and scarring of right lateral and posterior costophrenic angles.
EX 3	Ward	BCR[5]	7/28/05	7/29/05		No evidence of acute disease or interval change, COPD, mild scarring, cardiomegaly
DX 12	Abramowitz	B/BCR	6/7/05	11/22/05	1	1/2, s/t
DX 11	Rasmussen[6]	B	6/7/05	6/9/05	1	1/0 t/s

[3] Miner admits to smoking .5 packs per day for 40.5 years and six cigarettes, or .3 packs per day for 1 year, which yields a 20.55 pack year smoking history. A "pack year" is the equivalent of smoking one pack of cigarettes per day, or 20 cigarettes per day, for one year. So if you smoked 20 cigarettes per day, or a pack, for one year, on a regular basis, that would be one pack year. Therefore a 50 pack year smoking history could either mean the individual smoked one pack per day for 50 years, or two packs per day for 25 years.

Exhibit	Doctor	Qualifications	Date of X-ray	Date of Reading	Film Quality	Interpretation
EX 1	Wheeler	B/BCR	06/07/05	03/04/06	1	Negative; bu, em, pi
EX 3	Ahmed	B[7]	4/24/05	4/24/05		Cardiomegaly. COPD. Blunting scarring of right lateral posterior costophrenic angles. No definite focal pneumonia or effusion. Air trapping in the upper lung fields noted.
EX 3	Cappiello	B[8]/BCR[9]	9/28/04	9/28/04		COPD. Underlying pleural parenchymal fibrosis, unchanged. No cardiomegaly, CHF or acute infiltrate
EX 3	Miller	B/ BCR[10]	8/22/03	8/22/03		"scarring and chronic pleural thickening… no radiographic evidence of acute disease"
EX 3	Cappiello	B/BCR	3/23/02	3/24/02		(portable) "hyperinflation of the lungs with change of underlying COPD… new appearance of a small right pleural effusion."
EX 3	Pathak	B	2/28/02	3/1/02		(portable) "Mild to moderate cardiomegaly without CHF. No acute pulmonary pathology. Interval clearing of right basal pleural effusion."
EX 3	Pathak	B[11]	12/5/99	12/6/99		"COPD. Right infrahilar infiltrate could be due to pneumonia or scarring. Right pleural thickening with blurting of costrophrenic angle."
EX 3	Aycoth	B[12]	11/27/84	11/29/84		0/1, p/q "scattered rounded density opacities from 1.5 to 3mm in both lung fields. Lungs free of active disease."

Pulmonary Function Studies[13]

Exhibit #	Physician	Date of Study	Tracings Present?	Flow-Volume Loop?	Broncho-dilator?	FEV1	FVC/ MVV	Age/ Height	Coop and Comp. Noted
DX 11	Mullins	6/7/05	Yes	Yes	No	.96	1.96	63/67	Yes
DX 13	Hippensteel	12/07/05	Yes	Yes	yes	B 1.05/ A 1.26	B 1.78/ A 2.26	64/68	Yes; low effort

[4] I take judicial notice of B-reader certification. This physician was identified as a B-reader in the NIOSH Comprehensive Reader List found at: http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3EF_08_05.HTM.

[5] I take judicial notice of board certification in radiology. The American Board of Medical Specialties provides this information at http://www.abms.org/.

[6] The quality of this x-ray was reviewed and validated by Dr. Gaziano. (DX 11).

[7] I take judicial notice of B-reader certification.

[8] I take judicial notice of B-reader certification.

[9] I take judicial notice of board certification in radiology. The American Board of Medical Specialties provides this information at http://www.abms.org/.

[10] I take judicial notice of board certification in radiology. The American Board of Medical Specialties provides this information at http://www.abms.org/searchdetail.asp?key=61893.

[11] I take judicial notice of B-reader certification.

[12] I take judicial notice of B-reader certification.

[13] 20 C.F.R. 718 Appx. B establishes the standards for the administration and interpretation of pulmonary function tests.

EX 2	Castle	3/7/06	Yes	Yes	Yes	B 1.19 A 1.43	B 1.72 A 1.94	64/68	No

Arterial Blood Gas Studies[14]

Exhibit #	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Age	Comments
DX 11	Mullins	6/7/05	0-2999	R E	46.4 44.5	61.9 64.5	63	Unable to reach target heart rate – too tired
DX 13	Hippensteel	12/7/05		R	40.2	73.5	64	Normal gas exchange at rest; carboxyhemoglobin level is elevated consistent with continued smoking
EX 2	Castle	3/7/06		R	41.4	67.1	64	
EX 3	Princeton Community Hospital	4/27/05		R	35.7	53.0	63	

Other Medical Evidence

Exhibit #	Physician	Type of Record	Date of Report	Summary
EX 3	Groten	CT Scan	2/21/06	"Findings consistent with centrilobular emphysema… a focal, predominantly interstitial infiltrate is identified in the right lower lobe… Subsegmental atelectasis and/or scarring is noted in the right upper lobe.. findings consistent with chronic interstitial lung disease… pleural thickening is noted posteriorly in both hemithoraces." Impressions include focal increased density in right lower lobe, which most likely represents chronic scarring and/or atelectasis. "Pneumonia and malignancy are felt to be less likely." There is a small right adrenal gland mass. Mediastinal lymphadenopathy is seen. "Findings consistent with COPD and probable chronic interstitial lung disease are appreciated."
EX 3	Groten	CT Scan	5/10/06	The focal increased density is still present, which is thought to be chronic scarring. Subsegmental atelectasis or scarring is located in the upper right Findings are consistent with centrilobular emphysema and chronic Interstitial lung disease. There are no new suspicious pulmonary parenchymal masses or focal alveolar infiltrates. The stable mediastinal lymphadenopathy is noted.

[14] 20 C.F.R. 718 Appx. C establishes the standards for the administration and interpretation of arterial blood gas studies.

Medical Opinions

Dr. Norma J. Mullins (DX 11)

Claimant chose Dr. Norma J. Mullins to conduct the pulmonary evaluation required under 20 C.F.R. § 725.406. The evaluation consisted of a physical examination, a medical and work history, a chest x-ray, and pulmonary function and arterial blood gas tests. Dr. Mullins issued her report, dated June 15, 2005, to the District Director. (DX 11). Her report reflects that her conclusions were based on a coal mine employment history of 11 years[15] and a smoking history of half a pack per day for 46 years, which ended in March of 2005. (DX 11). Dr. Mullins was aware that Miner had pneumonia numerous times, suffered an attack of wheezing in 1993, was diagnosed with chronic bronchitis in 1998 and suffered from arthritis for 30 years, from seasonal allergies for 40 years and from high blood pressure for 20 years. (DX 11). Dr. Mullins was also informed that Miner suffered two heart attacks in 2002, which necessitated the placement of two stents. Regarding Miner's present illness, Dr. Mullins documented the presence of daily sputum, wheezing and coughing in the mornings, as well as dyspnea upon exertion, two pillow orthopnea, paroxysmal nocturnal dyspnea, chest pain and ankle edema. Dr. Mullins also reported that shortness of breath prevented Miner from lifting, climbing and walking. (DX 11).

Upon physical examination, Dr. Mullins found a normal configuration upon inspection of the lungs. She noted "bilateral wheezing" on auscultation of the lungs. (DX 11). Dr. Mullins found that the chest x-ray showed coal workers' pneumoconiosis with a profusion of 1/0.[16] Dr. Mullins also noted the results of the arterial blood gas study and the pulmonary function tests. Dr. Mullins provided the following cardiopulmonary diagnoses: "abnormal x-ray (consistent with coal dust exposure), CWP[17], COPD[18], CAD[19]." (DX 11). It is Dr. Mullins' opinion that coal mine employment was the primary cause of Miner's diagnoses; she listed CWP, smoking, family history and hypertension as secondary causes. Dr. Mullins concluded that Miner had a "severe ventilatory impairment which would have prevented [the] performance of the last coal mine job." She attributed half of the impairment to CWP, and the remaining half to "other" causes. She also reported the absence of non-cardiopulmonary diagnoses. (DX 11).[20]

James R. Castle (EX 2, EX 3)

Based upon both an evaluation of Miner and the review of additional medical records, Dr. Castle completed a medical opinion regarding the presence of CWP, dated April 26, 2006.

[15] The employment reviewed by Dr. Mullins listed 11 years in the coal mines as a general laborer and foreman, and also 6 years of work in the railroad business with exposure to coal. (DX 11).
[16] The x-ray taken in conjunction with this evaluation was actually interpreted by Dr. Rasmussen.
[17] CWP represents Coal Workers' Pneumoconiosis
[18] COPD represents Chronic Obstructive Pulmonary Disease
[19] CAD represents Coronary Artery Disease
[20] Dr. Mullins' curriculum vitae was not included in the record. I do take judicial notice of her board certification in internal medicine. The American Board of Medical Specialties provides this information at http://www.abms.org/searchdetail.asp?key=61893.

During the evaluation, Dr. Castle recorded Miner's past medical, family, social and occupational histories. Dr. Castle noted that Miner last worked in the coal mines as a foreman, had a total of 11 years of coal mine employment ending in 1971, and smoked less than half a pack per day for 45 years. Miner reported that he had trouble with his breathing for the last 15 years; could not climb a flight of stairs without using his inhaler; had a productive cough with sputum, had wheezing at night and in extreme weather and that he used oxygen at night. (EX 2 at 1 – 2).

Upon physical examination, Dr. Castle found Miner's lungs to be clear, with no rales, crackles or crepitations. Dr. Castle read the x-ray taken in conjunction with the exam to be negative for CWP. He did find radiographic evidence of cardiomegaly, right pleural effusion and a questionable mass in the right lower lung zone. (EX 2 at 3). Pulmonary function studies were conducted, however Dr. Castle found them to be invalid because of "inadequate exhalation time and less than maximal effort." Dr. Castle reported that the lung capacity was normal and there was gas trapping. The arterial blood gas study yielded results that were normal for Miner's age. An exercise blood gas study was not obtained because Miner had an abnormal electrocardiogram. (EX 2 at 3). Based solely on the data collected from the evaluation, Dr. Castle concluded that there was no evidence of CWP in either the physical or the radiographic evaluations. He opined that Miner had the "elevated carboxyhemoglobin level of a current smoker."

Dr. Castle also reviewed numerous pieces of medical data, including reports and comments by Drs. Rasmussen, Mullins and Hippensteel, all of which were included in the record. (EX 2 at 7). Dr. Castle recognized smoking, cardiac disease, and obesity as potential risk factors for Miner's pulmonary disease. He also noted that Miner had worked in the mines for "a sufficient enough time to have developed [CWP] if he were a susceptible host." (EX 2 at 8). Dr. Castle stated that it was his "opinion with a reasonable degree of medical certainty based on a thorough review of all the data including the medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gas studies, and other data that [Miner] does not suffer from coal workers' pneumoconiosis." (EX 2 at 8). As support, he reported that Miner did not demonstrate any physical findings consistent with interstitial pulmonary process, namely rales, crackles, or crepitations. He also stated that although Miner had numerous radiographic abnormalities, including a possible pleural effusion and a possible mass in the right lower lung zone, none of these abnormalities were consistent with CWP. He opined that Dr. Hippensteel's radiographic findings were in line with his own, and he further addressed Dr. Rasmussen's finding of CWP. Dr. Castle stated that "while Dr. Rasmussen opined that the x-ray was positive, he found linear, irregular type opacities in the mid and lower lung zones which are not typical of coal workers' pneumoconiosis." (EX 2 at 8).

Although Dr. Castle found the physiologic studies obtained at the time of his examination to be invalid, he opined that the "studies obtained by Dr. Mullins were probably valid and showed evidence of significant airway obstruction." (EX 2 at 9). Dr. Hippensteel's results indicated some reversibility associated with gas trapping. Dr. Castle concluded that those results were due to Miner's long and extensive tobacco smoking habit. With regards to the arterial blood gas studies, Dr. Castle commented that there was a variable degree of oxygenation, and that there is not a fall in PO2 with exercise. He explained that "the variability in oxygenation is due to ventilation/perfusion mismatching related to this tobacco smoke induced chronic airway

obstruction." (EX 2 at 9). He concluded that Miner "is very likely permanently and totally disabled as a result of tobacco smoke induced chronic obstructive pulmonary disease…[but] is not permanently and totally disabled as a result of coal workers' pneumoconiosis or a coal mine dust induced lung disease." (EX 2 at 9).

Dr. Castle is board certified in both internal medicine and pulmonary disease. He practiced medicine with Pulmonary Medicine Associates in Roanoke, Virginia, since 1977. He also practices with the Pulmonary Occupational and Research Consultants. He is licensed to practice in both Virginia and Florida. He has acquired a B- Reader certification. Dr. Castle is a member of numerous societies, including the American College of Physicians, The American Thoracic Society and the Medical Society of Virginia. Dr. Castle was a clinical professor of medicine at the University of Virginia, School of Medicine. Dr. Castle completed numerous publications, abstracts and presentations, all of which related in some way to pulmonary functioning. However, he has not written anything specifically about pneumoconiosis. (EX 2).[21]

Dr. Castle was deposed on December 7, 2006. (EX 5). Prior to the deposition, Dr. Castle reviewed numerous radiographic reports, as well as the medical records from Princeton Community Hospital. (EX 5 at 8 - 9). Dr. Castle first commented that the hospital records listed a more substantial smoking history than the history reported to Dr. Castle. He also explained that Miner had three pillow orthopnea, which "could be a symptom of significant cardiac disease, typically, where an individual cannot assume a reclining position because of cardiac problems." (EX 5 at 12). Based on all the information, Dr. Castle concluded that Miner's pulmonary impairment was due to tobacco smoking rather than coal dust exposure. He opined that the physical findings showed that Miner has a bronchospastic process with wheezing. Dr. Castle provided the following support for his contention:

> He has a history of working in the mining industry for about eleven or fifteen years or so, but he has a 50 to 100-pack-year smoking history, and I don't think that anyone actually found evidence of pneumoconiosis radiographically[22], and certainly, CT scans that were interpreted by Doctor Groten did not show that, and his physiologic function is typical of tobacco smoke-induced chronic airway obstruction, and that, plus the blood gases, looking at everything, that is what it is indicative of. (EX 5 at 15).

Dr. Castle diagnosed Miner with chronic bronchitis, which he attributed entirely to Miner's cigarette smoking. Dr. Castle explained that, with regards to industrial bronchitis, "the effects of [coal dust] exposure on bronchitis usually abates within six to eight months. [Miner] was continuing to smoke at the time of my examination, and therefore, he had an ongoing stimulus for his mucus production." (EX 5 at 17). Dr. Castle's final conclusion was that Miner did not suffer from either clinical or legal

[21] Dr. Castle reviewed more recent medical data and completed a supplemental report dated November 9, 2006. His conclusions remained unchanged. He concluded that Miner is totally disabled by tobacco smoke induced chronic obstructive pulmonary disease, coronary artery disease and obesity; none of which were caused or related to coal dust exposure. He still concluded that Miner did not suffer from CWP. (EX 4).

[22] Dr. Castle acknowledged Dr. Rasmussen's positive interpretation of an x-ray with a profusion of 1/0. Dr. Castle commented "the 1/0 means that although he felt that it was positive, he also considered that the film may be entirely negative." (EX 5 at 16).

pneumoconiosis. Upon cross examination, Dr. Castle acknowledged that Dr. Abramowitz provided a positive interpretation of the November 2005 x-ray with a profusion of 1/2, indicating the presence of irregular type opacities located in all lung zones. Dr. Castle does not provide any explanation of how this interpretation impacts his own conclusions. (EX 5 at 20).

Dr. Kirk Edward Hippensteel (DX 13, EX 3)

Dr. Hippensteel examined Miner on December 7, 2005. Dr. Hippensteel questioned Miner with regard to his medical, occupational and social histories. Dr. Hippensteel documented a coal mine employment history of 14 or 15 years. Dr. Hippensteel noted that Miner's last job was as a section foreman. Miner reportedly smoked between one third and one half pack of cigarettes per day for 10 years. Dr. Hippensteel noted that Miner had breathing trouble for approximately 10 years. According to Dr. Hippensteel's report, Miner had an allergy to ragweed, did not experience frequent upper respiratory infections, had pneumonia once three years prior, had not been diagnosed with asthma, and had not had tuberculosis exposure or bird exposure. Dr. Hippensteel reported that Miner was on a regular bronchodilator. Miner reported coughing up a teaspoon of gray sputum daily. He was also reported to have two stents placed for two myocardial infarctions he suffered in March 2003. Dr. Hippensteel also noted that Miner used oxygen at night, became lightheaded upon exertion and experienced chest pain. (DX 13).

Dr. Hippensteel listened to Miner's lungs during the physical examination and found "very mild rhonchi bilaterally with no rales heard." Dr. Hippensteel read the chest x-ray to be negative for pneumoconiosis, but it did show "cardiomegaly and some scattered calcified granulomas and a blunted right costophrenic angle with right basilar pleural thickening/effusion tracking up to minor fissure in right mid chest." Dr. Hippensteel reported that the spirometry showed "low peak effort/flow which makes for underestimate of his true function… so degree of obstruction is not determinable." However, he did state that Miner's lung volumes showed air trapping, which is indicative of obstruction. According to Dr. Hippensteel, there was no restriction. Blood gas studies were also conducted; the results indicated a normal gas exchange at rest and an elevated carboxyhemoglobin level consistent with continued cigarette smoking. (DX 13).

Dr. Hippensteel also reviewed Miner's claim for black lung benefits as well as his treatment records. Based upon this review and his findings from Miner's evaluation, Dr. Hippensteel concluded that the tests showed findings consistent with heart disease and obesity with suboptimal effort, so he was unable to determine Miner's exact level of functioning. He noted that Miner's gas exchange function was variable. Dr. Hippensteel attributed the findings of Drs. Mullins and Rasmussen to obesity and cardiac disease. He reported that "obesity and cardiac disease commonly cause a marginal increase in profusion of irregular marking in lung bases, as Dr Rasmussen thought was present… such findings are not diagnostic of coal workers' pneumoconiosis as Dr. Mullins claimed." Even though he was not able to definitively state whether Miner was totally disabled, he did state that if he were totally disabled, the impairment

would have been caused by 46 years of smoking[23] and obesity. He opined that Miner's elevated carboxyhemoglobin levels and variable gas exchange were consistent with continued smoking. Dr. Hippensteel explained that pneumoconiosis typically causes a fixed and permanent impairment, unlike the impairment indicated in this case. Ultimately Dr. Hippensteel concluded that Miner was totally disabled by his heart disease, obesity and other impairments, however Miner did "not have impairment referable to his prior coal mine dust exposure that would keep him from returning to work in the mines." (DX 13).

Dr. Hippensteel was deposed on November 21, 2006. Dr. Hippensteel reviewed addition medical data prior to his deposition, including numerous x-ray interpretations. (EX 6 at 13). Dr. Hippensteel concluded that Miner did not have clinical or legal pneumoconiosis. (EX 6 at 22). Dr. Hippensteel commented upon Miner's chronic steroid therapy. He explained that steroids are "used for bronchial inflammation that can be associated with reactive airways disease or asthma, and it is also used for exacerbations of bronchial inflammation that occur in cigarette smokers ..." (EX 6 at 11). Based upon the review of Dr. Mullins' report, Dr. Hippensteel stated that the extreme variability of the results are not typical or indicative of CWP because CWP typically causes a fixed or progressive impairment in gas exchange and pulmonary function.

Dr. Hippensteel is board certified in Internal Medicine with a subspecialty in both pulmonary medicine and critical care medicine. He is a member four professional organizations, which include the American College of Physicians and the American Thoracic Society. Although Dr. Hippensteel is not as prolific as Dr. Castle, he did receive numerous honors from the American Lung Association of Virginia. Dr. Hippensteel is a member of the active staff at Roanoke Memorial Hospital and Community Hospital of Roanoke. Currently, he is an associate professor of medicine at the University of Virginia School of Medicine. (DX 13).

Hospital and Treatment Records

A report, dated February 27, 2005, was filed at the Princeton Community Hospital noting Miner's history and physical status. The report stated that Miner admitted to smoking 1 - 2 packs of cigarettes per day for 50 years. The physical examination revealed bilateral expiratory wheezes with crackles noted at the base. The impressions upon admission included acute exacerbation of COPD secondary to acute bronchitis, hypertension, and coronary artery disease. (EX 3).

Miner was admitted to Princeton Community Hospital on April 24, 2005 for acute shortness of breath and increasing cough and dyspnea; he was discharged as stable on April 27, 2005. Miner once again admitted to smoking between 1 and 2 packs of cigarettes a day for 50 years. Upon examination, lungs were found to be "clear to auscultation with no rhonchi, wheezes or crackles." (EX 3). The principal diagnosis was acute exacerbation of COPD, with secondary diagnoses of hypoxia, cardiomegaly and nicotine abuse.

[23] Upon review of the medical evidence, Dr. Hippensteel noted that the other physicians reported a much more substantial smoking history that Miner had reported during his examination.

DISCUSSION

Because Miner filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Also, since this claim was filed after January 19, 2001, the regulations contained in 20 C.F.R. Part 718[24] as amended in 2001 are applicable. To establish entitlement to benefits under this part of the regulations, a claimant must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. §725.202(d); Anderson v. Valley Camp of Utah, Inc., 12 BLR 1-111, 1-112 (1989). In Director, OWCP v. Greenwich Collieries, et al., the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence. 114 S. Ct. 2251 (1994). Miner's coal mine employment took place in West Virginia, and therefore the rulings of the United States Court of Appeals for the Fourth Circuit control in the adjudication of this case.

Pneumoconiosis

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. §718.201(a)(1-2).

Section 718.202(a) provides four methods for determining the existence of pneumoconiosis, (1) x-ray evidence; (2) biopsy or autopsy evidence; (3) if applicable, the presumptions described in §§ 718.304, 718.305 or § 718.306 and (4) physician opinion evidence. Under § 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. Dixon v. North Camp Coal Co., 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. Woodward v. Director, OWCP, 991 F.2d 314, 316 n.4 (6th Cir. 1993); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128, 1-131 (1984).

[24] All of the regulations cited in this decision are contained in Title 20 of the Code of Federal Regulations.

This claim includes fifteen interpretations of thirteen x-rays.[25] Dr. Castle, a B-reader, provided the sole interpretation of the March 7, 2006 x-ray. He read the x-ray to be negative for pneumoconiosis. Dr Ahmed, a B-reader, provided a narrative interpretation of the February 14, 2006 x-ray. He reported the presence of minimal plate-like atelectasis behind the sternum, and right peripheral pleural thickening and blunting or scarring of the costrophrenic angles. He also noted that there were no new pneumonic infiltrates. He does not specifically diagnose CWP. I therefore find his interpretation to be too vague to establish the presence of pneumoconiosis. The December 7, 2005 x-ray was interpreted as negative for pneumoconiosis by Dr. Hippensteel, a B-reader. Dr. Ahmed provided a narrative interpretation of the September 27, 2005 x-ray. He found evidence of COPD, right peripheral pleural thickening and blunting or scarring, but he did not find evidence of clinical pneumoconiosis. Dr. Ward, a board certified radiologist, provided a narrative interpretation of the July 28, 2005 x-ray; he found COPD and mild scarring. He did not find any evidence of acute disease. He did not diagnose CWP. I find that the x-rays listed above fail to establish the presence of coal workers' pneumoconiosis.

Three physicians provided interpretations of the June 7, 2005 x-ray. One dually qualified physician interpreted the x-ray as positive for pneumoconiosis with a profusion of 1/2. Another dually qualified specialist read the x-ray to be completely negative. The third physician is a B-reader and read the x-ray to be positive with a profusion of 1/0, which indicates that although he classified this x-ray as positive, he seriously considered the possibility that the x-ray was negative for pneumoconiosis. Also, 1/0 is the lowest qualifying profusion classification. Two dually qualified specialists disagree about whether this x-ray shows the presence of pneumoconiosis. A lesser qualified physician read the x-ray to be positive, but seriously considered the x-ray to be negative. Therefore, I find this x-ray to be in equipoise.

There are seven x-rays in the record that were taken between the years of 1984 and 2005. There is a single narrative interpretation of each x-ray. While four of the interpretations diagnose COPD and pleural thickening, none of the interpretations specifically mention clinical pneumoconiosis. The 1984 interpretation lists the presence of "scattered rounded density opacities from 1.5 to 3 mm in both lung fields." However, the physician concluded that the x-ray was negative for pneumoconiosis with a profusion classification of 0/1. I find that these seven x-rays fail to establish the presence of pneumoconiosis. Overall, I find that Claimant has not established the presence of pneumoconiosis through radiographic evidence under 20 C.F.R. §718.202(a)(1).

Under § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable to this claim because the record contains no such evidence.

Under § 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at §§ 718.304 to 718.306 applies. The presumptions at §§ 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and

[25] Many of the x-ray interpretations in the record were not recorded on an ILO-UICC/Cincinnati Classification of Pneumoconiosis form, which is the most widely used system for the classification and interpretation of x-rays for the diagnosis of pneumoconiosis.

June 30, 1982, respectively. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Complicated pneumoconiosis is diagnosed after a finding of an opacity greater than one centimeter is categorized as a type A, B or C. This section is also inapplicable because there is no evidence in this case that may lead to a finding of complicated pneumoconiosis.

The final method by which Claimant can establish that he suffers from the disease is by well- reasoned, well-documented medical reports as per §718.202(a)(4). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. Hoffman v. B&G Construction Co., 8 B.L.R. 1-65 (1985); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. Fields, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. Wilburn v. Director, OWCP, 11 B.L.R. 1-135 (1988). Medical opinion evidence may establish either clinical or legal pneumoconiosis.

Dr. Mullins is the only physician of record to diagnose coal workers' pneumoconiosis. She based this diagnosis on the x-ray dated June 7, 2005. Dr. Rasmussen had read that x-ray to be positive for pneumoconiosis, which is contrary to the finding of the Court. It is proper for the administrative law judge to accord less weight to a physician's opinion that is based on premises contrary to the judge's findings. Furgerson v. Jericol Mining, Inc., 22 B.L.R. 1-216 (2002)(en banc) (the ALJ 'did not reconcile (a) physician's diagnosis of pneumoconiosis, based upon the positive x-ray and the miner's significant duration of coal dust exposure, with the fact that Dr. Baker's positive interpretation was reread as negative by a physician with superior qualifications'; as a result, the Board directed that the ALJ 'address whether this rereading impacts the physician's opinion and his diagnosis of pneumoconiosis'). Dr. Mullins provided no other explanation for the diagnosis of clinical coal workers' pneumoconiosis. Dr. Mullins also indicated the presence of COPD, but she did not clearly connect the obstructive impairment with Miner's coal dust exposure. Although Dr. Mullins' opinion was based on sufficient medical data, and was therefore well-documented, her opinion was not well-reasoned. I grant Dr. Mullins' medical opinion diminished weight.

Dr. Castle completed a physical examination of Miner and also conducted an extensive review of medical evidence. He concluded that Miner did not suffer from clinical or legal pneumoconiosis. He stated that Miner did not have clinical pneumoconiosis based upon the lack of radiographic evidence. He concluded that the x-rays did not establish the presence of pneumoconiosis, which is in line with the findings of the Court. He also opined that the CT scan readings did not indicate the presence of the disease either. After a review of Miner's medical

data, Dr. Castle opined that Miner suffered from an obstructive impairment, but he did not believe that Miner had legal pneumoconiosis. He explained that the physiological findings were not consistent with an impairment caused by coal dust exposure. Dr. Castle reported that the spirometry indicated severe airway obstruction with a retention of some CO2, which is typically indicative of a smoke-induced airway obstruction. Dr. Castle based his opinions upon substantial medical data and accurate smoking and employment histories. He used this data as support for his contentions. I find Dr. Castle's opinion to be both well-reasoned and well-documented.

Dr. Hippensteel also performed a physical examination and reviewed additional medical evidence. Although the conclusions listed in Dr. Hippensteel's report were based on a drastically deflated smoking history, Dr. Hippensteel obtained a more accurate smoking history from the additional medical evidence he reviewed. Like Dr. Castle, Dr. Hippensteel also concluded that Miner did not suffer from clinical or legal pneumoconiosis. He explained that the radiographic and physiological evidence failed to support such a diagnosis. He said Miner's impairment was treated with bronchodilators, which indicated a reversible impairment. He opined that the variability in the results of the function tests and the reversibility indicated by the use of steroid treatment were more consistent with a tobacco smoke induced impairment. He explained that CWP typically causes a progressive or fixed impairment. I find Dr. Hippensteel's opinion to be well-documented and well-reasoned.

Both the CT scan evidence and the hospital records support the conclusions of Drs. Hippensteel and Castle regarding the lack of evidence supporting the diagnosis of pneumoconiosis. Dr. Castle explained that CT scans may be useful in diagnosing pneumoconiosis. Dr. Groten provided two CT scan interpretations. In both interpretations he noted the presence of a "focal increased density" but opined that it was probably scarring. He diagnosed emphysema and chronic interstitial lung disease. But he did not specifically find opacities or changes consistent with clinical pneumoconiosis. The hospital treatment records indicate the presence of acute COPD. While the records mention nicotine abuse, they do not indicate any connection between the obstruction and coal dust exposure.

I rely on the consensus between Drs. Castle and Hippensteel. I find that the preponderance of the probative medical opinion evidence did not support a finding of legal pneumoconiosis.

Miner did not establish the presence of clinical or legal pneumoconiosis; therefore the other three elements of entitlement are moot. The preponderance of the evidence does not support a finding of pneumoconiosis, therefore Miner's claim for benefits must be denied.

ORDER

D.F..'s claim for benefits under the Act is hereby **DENIED.**

A

LARRY W. PRICE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).